MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address SAN ANTONIO ORTHOPAEDIC SURGERY CENTER 400 Concord Plaza, Suite 200 San Antonio, TX 78216	MDR Tracking No.: M4-05-1029-01 TWCC No.: [redacted] Injured Employee's Name: [redacted]
Respondent's Name and Address **Box 42** NORTH EAST ISD 8961 Tesoro Dr, Suite 209 San Antonio, TX 78217	Date of Injury: [redacted] Employer's Name: [redacted] Insurance Carrier's No.: [redacted]

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/07/04	06/07/04	20680-LT	$3,787.83	$0.00
06/07/04	06/07/04	64445-59	$1,004.78	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for Increased Reimbursement or Refund submitted on the TWCC-60 stated, The Carrier has not provided the proper payment exception code in this instance, which is in violation of the Texas Administrative Code. Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements.

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's Rationale for maintaining the reduction for denial submitted on the TWCC-60 stated, Carrier has used valid TWCC Payment Exception Codes. References: Electronic submission of Medical Bill Information, UB-92, ECS, Table 2, Medical payment exception codes, August 2003. Carrier has reimbursed at "fair and reasonable" using Medicare ASC payment rates, multiple surgery rule/policies, and the additional modifier of 2.133. Respondent's Position submitted stated: Carrier has rendered "fair and reasonable" reimbursement and utilized correct payment exception codes when denying/reducing payment amounts. Also carrier concluded, Carrier maintains that payment was "fair and reasonable" and valid Payment Exception Codes were used.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it does not appear that the requestor nor respondent provided documentation that sufficiently discusses, demonstrates, and justifies their purported billed (charges) or reimbursement amount are a fair and reasonable reimbursement as required by Commission Rule 133.307.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 213.3% to 290% of Medicare for this particular year-2004). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. After reviewing these facts and the reimbursement previously made on this claim, it was determined that **no** additional reimbursement was required to reach this range established by the Ingenix study. Based on this review, there was no indication of underpayment and no additional reimbursement due. The recommendation was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommendation, discussed the facts of the individual case, and selected the appropriate amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the requestor is **not entitled to** additional reimbursement for these services.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

Authorized Signature	Amy L. Rich Typed Name	8-3-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives Box 42 on 8/4/05. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: 8/5/05